UNIVERSITY OF MICHIGAN
JL 23 1951
SCIENCE LIBRARY

BULLETIN of the MENNINGER CLINIC

Vol. 15, No. 4 July, 1951

Contents:

The Autonomy of the Ego. *By* David Rapaport, Ph. D..... 113

The Purposive Organization of Case Material. *By* Karl Menninger, M.D..... 124

Administration—A Point-of-View for Psychiatrists. *By* Irving Sheffel..... 131

Chronic Psychosis as a Sequel to Measles Encephalitis. *By* William S. Simpson, M.D..... 141

Reality and Dream. Book Review by Weston La Barre, Ph.D.. 149

Book Notices 150

Copyright 1951, The Menninger Foundation, non-profit, for Psychiatric Treatment, Education and Research, Topeka, Kansas

Topeka
Kansas

BULLETIN of the
MENNINGER CLINIC

VOLUME 15 JULY, 1951 NUMBER 4

Published bimonthly by the Menninger Foundation. Annual subscription rate, $3. Single numbers, 50¢. Manuscripts and orders should be sent to the *Bulletin of the Menninger Clinic*, Topeka, Kansas. Members of the Editorial Board: Jean Lyle Menninger, H. C. Modlin, M.D., Rudolf Ekstein, Ph.D., Benjamin Rubinstein, M.D. Consulting editors: Karl Menninger, M.D., W. C. Menninger, M.D. Editors' Assistant, Mary D. Lee.

THE AUTONOMY OF THE EGO*

By DAVID RAPAPORT, Ph.D.†

In attempting to understand and to encompass theoretically the nature of thought-processes, the problem of the autonomy of the ego recurs more often than any other. Even though much of what I present in describing this problem will not be original, or new, or even clearly related to the theory of thought-processes, yet I feel that these considerations are not only indispensable postulates for a psychoanalytic theory of thinking,[1] but are also of paramount importance both in general and in therapeutic research.

I

A story from the Talmud illustrates some fundamental issues encountered by psychoanalytic ego psychology. There was an Eastern king who heard about Moses. He heard that Moses was a leader of men, a good man, a wise man, and he wished to meet him. But Moses, busy wandering 40 years in the desert, couldn't come. So the king sent his painters to Moses and they brought back a picture of him. The king called his phrenologists and astrologists and asked them, "What kind of man is this?" They went into a huddle and came out with a report which read: This is a cruel, greedy, self-seeking, dishonest man. The king was puzzled. He said, "Either my painters do not know how to paint or there is no such science as astrology or phrenology." To decide this dilemma, he went to see Moses and after seeing him he cried out, "There is no such science as astrology, or phrenology." When Moses heard this he was surprised and asked the king what he meant. The king explained, but Moses only shook his head and said, "No. Your phrenologists and astrologists are right. That's what I was made of! I fought against it and that's how I became what I am."

This story is a good allegory of the first encounter of psychoanalysis

* Presented at a seminar of the Menninger School of Psychiatry, Winter Veterans Administration Hospital, June, 1950.

† Austen Riggs Foundation, Stockbridge, Mass.

with ego psychology. It speaks of the recognition that there are other things to a human being besides the drives. Psychoanalysis at first assumed that these other things were defensive structures which were born of conflict.[2, 3] But ego psychology did not stop at this point. Let us raise a few questions from the Moses story and see what kind of problems ego psychology had to face afterward.

First, what does it mean: "I fought against it"? On the "fought" we can easily agree: that means *conflict*. But what conflicted? The old conception which prevailed before the advent of ego psychology[4] was a conflict of drives with the censor. After the concept of the ego was already coined, it was assumed that the ego and the id conflicted, and yet we learn that the ego itself was born out of conflict.[5] So the first problem that budding ego psychology met was: How are the participants of the conflict to be conceived of? This is one of the points I propose to discuss.

The second question is: If he "fought against it" and became what he was, what happened to that which he "was made of"? Did it vanish? The Bible says that Moses was not quite the holy man without spot. When he was told to touch the rock, he hit it. He acted like *he* was doing the wonders and not the Lord. When he descended from Mount Sinai, after communing with the Lord, and saw the golden calf and the erring of his people, he got into a violent rage and broke the Tablets.

This much is already clear: even though Moses by his struggle became somebody very different from the stuff he "was made of," in moments of strain, that grandiose, competitive, raging, immodest stuff of which he was made, and which the astrologists and phrenologists saw in his features, made its appearance in his behavior. We realize that this is how it always happens in psychological life. So we need not be concerned that we may be accused of forgetting, like Horney, the persistence underneath of what the struggle seems to have conquered, when we speak of what someone became by a struggle against his impulses, that is, when we deal with the *function* of the ego. We do not forget, even if our emphasis is on the ego, that Moses was not altogether "holy" though he fought against the "unholy" things within him which we nowadays call impulses and drives.

There is yet a third question: How is it possible for the ego to let something that it has conquered come through, as it did in the case of Moses in the Tablet and the Rock episode?

II

Before discussing these three points, I will raise yet another consideration. When psychoanalysis was young, and people did not read all Freud had to say about psychic life, for instance the VIIth chapter of *The Interpretation of Dreams*, or the *Metapsychological Papers*, the impression was

that he conceived of psychic life as an ever-seething cauldron, that strivings clashed continuously with each other without mitigation, in a perpetual revolution, and every time something happened in consciousness or behavior it issued from a new equilibrium reached by clashing drives. In borderline and psychotic patients we observe at times a state which, in a mild form, resembles this conception. I needn't remind you how consuming, devastating, and paralyzing such states are. Yet such was the early psychoanalytic conception—not Freud's conception, but certainly Stekel's,[6] and others'.

Adler, and later Horney and others, tried to get away from this conception of the seething cauldron, and gave their attention to the adaptive and social functions of the ego. They came to do so in part, by virtue of the carefulness of their observations, which showed them the relative stability of the defensive, adaptive, and social motivations of man; a field of observations which was at the beginning outside of the sharp focus of psychoanalytic study. But they did so in part as a result of the carelessness of their understanding of Freud's psychoanalysis, which was by no means just a conception of the seething cauldron, but had in its concepts of resistance, defense, and secondary process, the nucleus of an ego psychology. In revolt against the conception of the seething cauldron they did not note these. They proceeded to build anew, rejecting the drive psychology of psychoanalysis, which they equated with the conception of the seething cauldron.

The seething cauldron concept and the concept which wants to get away altogether from the beasts that struggle down under somewhere, this thesis and antithesis, found a synthesis in psychoanalytic ego psychology, which recognizes the id forces as well as the new organization, the ego, which is pitted against them. This organization has a certain degree of constancy and reliability: It cannot and need not be created totally anew in every clash of id-forces with each other, with reality, or with it. The nature and degree of this constancy and reliability, or as we have come to refer to it, this autonomy,* is the subject of this paper.

An emergent organization is one which has laws of its own, distinct from those of the elements which constitute it: such as, for example, the social group when viewed in relation to the individuals composing it. Such emergent organizations partly control, and are partly controlled by, the underlying organizations from which they emerged. In the study of organic matter, in that of the nature of man, and in that of society, we encounter at every step such emergent organizations.

Let me give you an example, which though it disregards many social realities, yet contains a true, though oversimplified, moral. Suppose that

* The concept was coined by Heinz Hartman.[7]

20 of us should land on a desert island. At first we would all try to do all the jobs, mutual assistance and good will running rampant. But since the nature of man is what it is, quarrels would start and some people would begin to stake out their claims. It might begin with the question, "Who should do the dirty jobs, and who the others?" And then, "Which is a dirty job and which isn't?" A division of labor would sooner or later, of necessity, be established, and once a division of labor has come into existence it is very hard to change. Why? Because the people who have been at a certain labor for a while will know best what and where the tools for it are, and they will know most about that work. There will be symbols and status attached to the work and workers as time goes on. A society will have slowly formed in which, over and above the original mutual good will which prevailed at and soon after the landing and over and above the personal predilections and aversions, a new set of rules—a division of labor and know-how and symbols representing these—take precedence. These rules and divisions become perpetuated by the children perceiving their own parents' occupations and preoccupations, by their hearing about "do's" and "don't's." Thus develops a social structure which is relatively independent of the original good will, of the original competitions, and is often even contrary to these.

This is a very superficial simile of a society's birth. But there is a true core in it: The so emerging organization has a considerable degree of independence from the individuals who are the members and even originators of it! Social groups constitute themselves thus so that they may survive for generations. People are born and people die, but roles and rules remain. Suddenly after generations, internal, economical and other forces may break this framework of autonomy and a revolution is at hand. The psychological apparatus, too, is such an arrangement of emergent organizations. Understanding the personalities of individual participants does not explain a social happening. Similarly, the understanding of a person's drives, drive-conflicts, and drive-vicissitudes alone, will not make his personality, nor even necessarily his pathology understandable. We have good evidence for this in the many unsuccessful attempts at creating a psychiatric nosology based on drive-vicissitudes.*

Another sort of supporting evidence comes from the preconference evaluations of the patient made by analysts of exclusively psychoanalytic training. These evaluations were based usually on a free-association interview which revealed how well the patient could free-associate, and what drive-constellations and overt behavior he displayed—but little or nothing was,

* Dr. Karl Menninger and his associates arrived, after many attempts to build a nosology on drive vicissitudes, at a nosology free of such interest (book in preparation).

as a rule, learned from it about the patient's personality as a whole, his strength, assets and prognosis. Without an orientation toward—and without technical skill for—the understanding of psychic structure, the knowledge of drives and conflicts cannot give a rounded picture of the personality. A psychological theory in terms of energy distributions, lacking structural concepts, does not make a psychology. This is why even before the *Ego and Id*, Freud in his *Metapsychological Papers* insisted that without simultaneous understanding of the dynamics, topography, and economy of a psychological event, there is no full understanding of it.

Similarly, Fritz Heider has pointed out that one of the major weaknesses of the dynamic psychology of Kurt Lewin is, that it has not structural concepts. This holds for other systems of psychology also, for example, Tolman's and particularly for the Yale school's (Hull, Dollard, Sears, Doob, Miller). Regrettably, psychoanalysts attempting to make a liaison with psychology, and psychologists attempting to make liaison with psychoanalysis, appear to forget that a viable psychology must have both energy-dynamic and structural concepts. Striking examples of this obliviousness are: Thomas French's paper[8] on the relation of conditioned reflex and psychoanalysis, Masserman's theory,[9] O. H. Mowrer and Clyde Kluckhohn's paper[10] on the relation of learning theory and psychoanalysis.

III

Our first question as to the nature of the autonomy of the ego was: If the ego grows on conflict, how are we to conceive of the participants of this original conflict? Note the circularity: The ego is both born out of the conflict, and party to the conflict. How can we explain this seeming contradiction? The answer can be seen in the study of infants in the individual differences between infants which are present from the very beginning of development, suggesting inborn personality determinants *in nuce*.[11] It may be seen in one of Freud's last papers "Psychoanalysis, Terminable and Interminable," in which he directly postulates inborn, inherited ego factors. It can be seen also when we consider that after all psychology has found some general laws of perception, memory, and learning which show some interindividual consistency. Let us forget for a moment that we would want to restudy these three functions from the point of view of psychoanalytic ego psychology, and that in recent studies these interindividually consistent laws have yielded individual differences and gained a new meaning.[12] Whatever interindividual consistency there is in these functions shows that these apparatuses of perception, memory, and motility, are inborn and characteristic of the species and the biological individual, before they become expressive of conflict and experience. Memory, perception, and motility, have already been existing and functioning before con-

flict ever occurred. Here then we see apparatuses which antedate conflict, and may become the core of ego development. Indeed we know that these apparatuses may remain, in many cases, outside of conflict later on also. It is thus that a patient on the verge of psychosis, totally helpless to deal with his problems, and torn in every respect, may nevertheless display on the couch, or in the interview, or in testing, an amazingly accurate memory, or sensitive perception, or perfection of motility.

It was Heinz Hartmann who gave the first systematic evaluation of the role of these apparatuses in ego development. He labeled the autonomy of these apparatuses "primary autonomy." The functions which are at any given time outside of the range of conflict he conceptualized as belonging to the conflict-free ego sphere.[7] From the role of this primary autonomy in ego development, he concluded that our usual conception that the id preexists the ego is inadequate, that there must be a period in human individual development in which what will later be the ego, and what will later be the id, coexist, as yet undifferentiated from each other; and that it is by the differentiation from an initial undifferentiated phase that both the ego and the id arise.[13, 14]

Psychologists concerned with the psychology of development, and biologists concerned with instincts, have recognized something like this much before Hartmann. Indeed, rereading material like that summarized by Heinz Werner in his *Developmental Psychology*,[15] clearly suggests an initial undifferentiated phase in which percepts are physiognomic, concepts are syncretic, and experience is diffuse. Biologists, on the other hand, have recognized that domestication alters instinct behavior. The rigid coordination of drive tension and goal, so clear, for example, in insects, is lost in the course of domestication.[16] It was again Hartmann who clarified this issue, concluding that in the human individual, drives are not as adaptive reality-attuned as they are in the animal; the id is reality-distant, while animal instincts are primary guarantees of survival by virtue of the strict coordination of drive tension and drive object.[14, 17]

The inborn ego apparatuses, and their integration into the ego, which, just like the id, develop from an originally undifferentiated matrix by differentiation, provide the way out of the paradox described above. Yet, without an additional consideration, the answer to the question, "What conflicted with the drives?" may not be clear. We must remember that the motor, perceptual, and memory apparatuses, as well as other inborn apparatuses such as those of affect expression, stimulus barrier, etc., have definite thresholds which are their *structural characteristics*. These *structural characteristics* will set limits to the discharge of drive tension, that is to the pleasure-principle, even when the need-satisfying object is present, and even before drive-discharge is prevented by the absence of the need-satis-

fying object. The very nature of structure will always prevent total discharge of tension. The existence of inborn structural elements in the undifferentiated phase may be what precipitates developmentally the differentiation of it into the ego and the id. The developing ego then integrates these structural apparatuses and re-represents their discharge-limiting and -regulating function in forms usually described as defenses. These are the foundations of the primary autonomy of the ego.*

IV

There is, however, more to ego autonomy, and to get a closer view of this "more," and get closer to the answer to our second question, let us turn to Freud's model of primitive psychic function.[18] According to this model, when drive tension rises and the need-satisfying object is absent, instead of the tension discharge which would occur were the need-satisfying object —say the breast—present, a new distribution of tensions—that is, energies —occurs. We describe this new energy distribution by saying that the drive which cannot be satisfied, is repressed. Metapsychologically we formulate repression thus: a countercathexis is pitted against the cathexis (energy-charge) of the repressed drive.

This is not only a model of instinct-vicissitude, but also one of the development of the ego. The countercathexis reflects a reality fact: the unavailability of the need-satisfying object. The model thus represents the internalization of reality, which is one of the crucial characteristics and functions of the ego. This internalization is not only a modification of the distribution of drive cathexes by the impact of reality, but also a crucial step in the development of thought organization. Instead of drive discharge, prevented first by the absence of the object and later by repression, there arise on the one hand, affect discharge observed as affect expression, on the other, ideational representations, in the form of wishfulfilling, hallucinatory images. In the illusions of people on the verge of starvation or dehydration, and in the hallucinations of schizophrenics, we have phenomena substantiating the heuristic value of this model.

Reality is then internalized and represented in the psychic apparatus, not only by the countercathexis of repression, but also by the arising ideational representation, and indirectly even by the affect discharge. The countercathexis of repression is only one of the countercathectic energy distributions which arise in this fashion. Every defense mechanism we observe, corresponds to such a countercathectic energy distribution. Each of these is a new apparatus of the ego, added to the already discussed inborn

* Compare Piaget, Jean: "The Biological Problem of Intelligence," Chap. 7, pp. 176–192. In: *Organization and Pathology of Thought* by David Rapaport (New York, Columbia University Press, 1951).

ego apparatuses. They, arising in the course of the differentiation process of the ego and the id from the undifferentiated phase, also serve to control drive discharge. These defensive apparatuses come to our attention in the form of motivations of behavior, such as denial, avoidance, altruism, honesty, etc. These motivating forces, too, are relatively autonomous, and constitute what "more" there is besides inborn autonomous apparatuses to ego autonomy. They are what Moses referred to in the story saying: "That's how I became what I am."

To demonstrate to ourselves the autonomy of these defensive apparatuses (secondary autonomy), let us take another look at their development. There was a clash between drive-need and reality. Out of this clash arose controlling apparatuses. Some of these, once they arose as emergent organizations, became relatively independent from the source of their origin. How do we know? We know that in our therapeutic work we encounter defenses which we do not manage to break down even in many years of analysis. You could counter this with, "That is no proof. More and better analysis would have penetrated these!" Possibly. But the very fact of difficulty in analysis bespeaks relative autonomy.

But there is more telling evidence for this autonomy than the pragmatic consideration just advanced. We have known from reconstructions in psychoanalysis for many years that many altruistic, esthetic, and anti-violence motivations are somehow related to reaction formations against impulses of the anal-sadistic phase. Anna Freud reported* that they observed in their Hempstead Nurseries that children who displayed, in a particularly blatant fashion, behavior characteristic of the anal-sadistic phase, became later on very benign, nice youngsters, with keen liking for people and animals, and with a sharp aversion to cruelty. We have all seen, clinically, people similar to the youngsters Anna Freud observed, and saw that though we could analyze the reaction formation and its interferences with adjustment, altruism as a motivating *value*—though it arose as a reaction formation or an altruistic denial—need not be lost, and is mostly not lost, in successful analyses.

To generalize this point: What came about as a result of conflict, sooner or later may become independent of the conflict, may become relatively autonomous. This becomes particularly clear in studying thought processes: The developing independence of the secondary process from the primary one is not completely reversed even in many of the major schizophrenic thought disorders, but mostly persists side by side with the breaking-through primary process. This is probably what gave the "split" impression to early observers of schizophrenia, including Bleuler. I do not believe that any prolonged study of thought in various psychiatric disorders can leave

* In a meeting at the Austen Riggs Foundation, Stockbridge, May, 1950.

anyone without the strongest impression that the secondary process once established shows such persistence against the onslaughts of conflict, and against the return of the repressed primary process, that it can be understood in no other way but by assuming that this is not due only to those apparatuses involved in thought (perception, memory) which have primary autonomy, but also to the persisting autonomy of apparatuses which have attained secondary autonomy.

But here we have come to the answer to our second question. While it is true that apparatuses of primary autonomy tend to *remain* such and to persist in the conflict-free ego sphere, and while defensive apparatuses born of conflict may become autonomous, and may function in the conflict-free sphere, and tend to retain their autonomy against the onslaught of conflict —nevertheless secondary and even primary autonomy is *relative*, and these apparatuses, too, may and do get involved or reinvolved in conflict. To give an extreme example: Motility, in spite of its primary autonomy, is involved in conflict in all hysterical motor disorders and schizophrenic motor mannerisms.

In other words, we have to conclude that the autonomy of the ego we are talking about, though it is a most impressive guarantee of independence from instinctual drives, of reality testing, and of social adaptation, is only relative, and may appear so impressive only because without it we would be entirely at the mercy of our impulses. Yet there are in every one of us some functions and structures, the autonomy of which proves irreversible in the course of our life history. Such persisting autonomy seen in a case history can be crucial in establishing the prognosis in severe schizophrenics and character disorders, provided that the basically guarded prognosis is not replaced but only modified thereby.

V

Superimposed on the original drive cathexes, new organizations of energy arise, which owing to processes of binding or neutralization, do not abide any more by the rules of the primary process, which is tension-level-lowering discharge at all costs. That is, the pleasure-principle is superseded by the reality-principle, by postponement of discharge, by detour, by experimental operation with small quantities of energy. These processes of binding or neutralization which progressively transform the discharge-bent drive energy to a system-bound form, seem to play a crucial role in the development of defensive apparatuses (secondary autonomy), and their motivations. Keeping this in mind, let us see whether we can obtain some kind of an answer to our third question about the occasional failure of the ego to bind the forbidden impulses.

To make my point concrete I want to refer to a group of borderline cases,

all of whom survived, as it were, on counterphobic defenses. Reckless wild tricks, fearlessness, apparent self-sufficiency, rebelliousness, denial of needs (including need for help), contempt and hate for all who show "weakness," were outstanding characteristics of them all. They were "independent" in the extreme, because they wished and feared dependence in the extreme. In some of these I have seen the dire effects of a direct interpretation of the aggressive meaning of their "independence," in the form of catatonic excitement. I have seen some of them run away when overactive therapy brought positive transference prematurely to a head, thus bringing on an overwhelming threat to their independence. I have seen some of them, however, where a profound respect for the independence and dignity of man permeated the therapeutic atmosphere and where the analysis of the counterphobic defense was extremely gradual and did not call in question independence as a value and motivation. The autonomy of the value-motivation was not attacked when the conflict-involved counterphobic defense was analyzed. In some cases therapeutic failure may be due to a lack of autonomy of the "independence striving" as a value-motivation, it being just one subordinate aspect of the conflict expressed in the counterphobic defense; in others it may be due to the therapist's neglect to distinguish between the autonomous value-motivation aspect, and the conflict-laden, defensive aspect of the same psychic formation.

The tentative answer to the third of the questions raised is: That autonomy, particularly secondary autonomy, is always relative, and the onslaught of drive motivations, especially when unchecked by therapeutic help or when aided by overzealous therapeutic moves, may reverse autonomy and bring about a regressed, psychotic state in which the patient is, to a far-reaching extent, at the mercy of his drive impulses. The higher level autonomous motivations are, as it were, dissolved, and the allies the therapist usually counts on—spontaneity and synthesis—are absent. Thus we can see that the issue of ego autonomy is not merely a theoretical problem but also a practical one of therapy, particularly in borderline and in psychotic cases.

What was conquered by Moses in his struggle lurks there, always ready to make an attempt to recoup its old ground. If it succeeds—we are faced with a psychosis. This recoup is rarely complete—all ego autonomy is hardly ever suspended—yet a sufficient part of this autonomy may be dissolved to warn us that the therapist of such a borderline case should respect and foster all autonomous ego functions to avoid their crumbling.

BIBLIOGRAPHY

1. RAPAPORT, DAVID: On the Psychoanalytic Theory of Thinking. *Internat. J. Psychoanalysis* 31: 161–170, 1950.

2. FREUD, SIGMUND (1894): The Defence Neuro-Psychoses, pp. 59–75. In: *Collected Papers*, vol. 1, London, Hogarth, 1924.
—— (1896): Further Remarks on the Defence Neuro-Psychoses, pp. 155–182. In: *Collected Papers*, vol. 1, ed. 3., London, Hogarth, 1946.
—— (1926): *The Problem of Anxiety*. New York, Psychoanalytic Quarterly Press, 1936.
3. FREUD, ANNA: *The Ego and the Mechanisms of Defence*. New York, International Universities Press, 1946.
4. FREUD, SIGMUND (1923): *The Ego and the Id*. London, Hogarth, 1927.
5. *Ibid.*, p. 36.
6. STEKEL, WILHELM: The Polyphony of Thought. Chap. 14, pp. 311–314, in *Organization and Pathology of Thought* by David Rapaport. New York, Columbia University Press, 1951.
7. HARTMANN, HEINZ: Ich-Psychologie und Anpassungsproblem. *Int. Z. Psa. Imago* 24: 62–135, 1939; for translation, see Chap. 19, pp. 362–396, in *Organization and Pathology of Thought* by David Rapaport. New York, Columbia Univ. Press, 1951.
8. FRENCH, THOMAS M.: Interrelations Between Psychoanalysis and the Experimental Work of Pavlov. *Amer. J. Psychiat.* 12: 1165–1203, 1933.
9. MASSERMAN, JULES H.: *Principles of Dynamic Psychiatry*. Philadelphia, W. B. Saunders Co., 1946.
10. MOWRER, O. H. AND CLYDE KLUCKHOHN: Dynamic Theory of Personality, pp. 69–135. In: *Personality and the Behavior Disorders*, vol. 1, J. McV. Hunt, ed. New York, Ronald Press, 1944.
11. ESCALONA, SIBYLLE AND MARY LEITCH: "Some Problems in Infant Psychology." Address to Topeka Psychoanalytic Society, Jan., 1951.
12. KLEIN, GEORGE: Adaptive Properties of Sensory Functioning: Some Postulates and Hypotheses. *Bull. Menninger Clin.* 13: 16–23, 1949.
——: Where is the Perceiver in Perceptual Theory. *J. Personality* 18: 32–47, Sept., 1949.
13. HARTMANN, HEINZ, ERNST KRIS AND RUDOLPH LOEWENSTEIN: Comments on the Formation of Psychic Structure, pp. 11–38. In: *The Psychoanalytic Study of the Child*, vol. 2. New York, International Universities Press, 1946.
14. HARTMANN, HEINZ: Comments on the Psychoanalytic Theory of Instinctual Drives. *Psychoanalyt. Quart.* 17: 368–388, 1948.
15. WERNER, HEINZ: *Comparative Psychology of Mental Development*. New York, Harper, 1940.
16. LORENZ, KONRAD: Der Kumpan in der Umwelt des Vogels. Der Artgenosse als ausloesendes Moment sozialer Verhaltungsweisen. *J. Ornith.* 83: 137–213, 1935.
THORPE, W. H.: The Modern Concept of Instinctive Behavior. *Bull. Animal Behavior* 7: 12, 1948.
17. HARTMANN, HEINZ: Ego Psychology and the Problem of Adaptation. Chap. 19, pp. 362–396, in *Organization and Pathology of Thought* by David Rapaport. New York, Columbia University Press, 1951.
18. FREUD, SIGMUND (1911): Formulations Regarding the Two Principles in Mental Functioning, pp. 13–21. In *Collected Papers*, vol. 4. London, Hogarth, 1925.
—— (1900): *The Interpretation of Dreams*, Chap. 7. Rev. ed. New York, Macmillan, 1933.

THE PURPOSIVE ORGANIZATION OF CASE MATERIAL

By KARL MENNINGER, M.D.

Editor's Note: The following article is the first of three sections from Part IV of a *Manual for Psychiatric Case Study* prepared for the use of Fellows in the Menninger School of Psychiatry. This will be published in book form by Grune & Stratton in the summer of 1951.

Part I, "The Approach to the Psychiatric Patient," was published in the *Bulletin of the Menninger Clinic* for November, 1950. The second half of Part IV, dealing with the prescription of a therapeutic program, will appear in the next issue of the *Bulletin*.

Diagnostic Analysis and Synthesis

Having accumulated the historical and examinational data, the psychiatrist is faced with the task of organizing them into a significant whole which can be used to plan the treatment program. This is always difficult and critical. One must bear in mind the axiom that there are certain ways in which all human beings are alike, certain ways in which many, but not all, individuals are alike, and certain ways in which no individuals are alike. In other words, each individual has certain things in common with others, and certain things which are strictly individualistic. *Some* of the things which a particular patient under examination has in common with some other people may be "normal," and others may be "abnormal." From the standpoint of the physician, abnormal means troublesome. We are really not concerned with how common a certain troublesome factor may be; we are concerned with what it does to interfere with the comfortable adjustment of the particular individual under study.

However, in reviewing the accumulated data of a case study for the purpose of planning treatment, the physician cannot limit himself to the troublesome features, the abnormal data. The assets and potentialities of the individual must be taken into consideration, as pillars upon which to build. Furthermore, both the positive and negative aspects of the environment in which he lives must be appraised in order to judge the time and circumstances under which he may be returned to it, or whether it could and should be modified. The purpose of a case study is not to paint a picture of the pathology present, but rather to define the way in which a certain personality is reacting to a certain situation. This situation may be a present one, or a long past one the effects of which are still felt, although the original noxious elements have disappeared. It may, again, be a series of such traumatic "situations" with variable punctuation. Or it may be a "life-situation," so-called, a complex of accepted and semi-accepted inter-

relationships which add up to an increasing burden for the individual which seems to be insoluble.

This is why it is so difficult to make an adequate case analysis. It is necessary to describe not only a changing environment and a changing individual living in that environment, but the changing reactions of that (changed) individual to that environment, and *vice versa.*

Most psychiatric case studies or analyses fail utterly to do this. In fact, some psychiatrists feel that it simply can't be done, and fall back upon the use of either long narratives with too much detail to be grasped by any ordinary listener or reader, or upon skeleton lists of events and symptoms without dynamic interpretation or meaningful integration.

Adolf Meyer struggled to remedy this with his famous life history diagram, a graphic representation of the development of the personality from birth up to the present illness, with the significant life events noted in the proper places along the cone. For many students the construction of this is an extremely helpful exercise. It emphasizes history more than examinational findings, however, and leaves rather insufficient opportunity for ordering these data and coordinating them with the historical data.

Franklin Ebaugh used a tabular rather than a graphic method of organizing these data, following the formula: I + S = R, meaning that the individual makeup, plus various factors in the situation, result in certain reactions. For example, a certain physical and psychological structure meets up with certain traumata with the result that a certain reaction of maladjustment follows. This formula is good, but oversimplified. It provides for tabular summary lists rather than dynamic analysis. It follows the old static rule of trying to list what a patient reacts with, what he reacts to, and how he reacts. But what a patient reacts *with* is always a result of what he has after he has reacted to something else, again and again and again. He has reacted *with* something *to* something many times before the present time, so that what he is reacting with *now* is the consequence of a great many repetitions of the formula with different values inserted. The static formula is not applicable, therefore, to what is really a dynamic situation.

Our attempt to solve this problem of analyzing the data of personality study with reference to a present picture is along the lines of the following formula:

As a result of what an individual is and has when he comes into the world (the heredo-congenital nucleus), *modified by the social, physical and psychological experiences of his* infancy and childhood, *he enters the crystallizing era of* adolescence, *during which the previously more plastic personality structure becomes "set" in a fairly characteristic form.* (The experiences of adolescence

have much to do with hastening or delaying this process of "hardening," and may also considerably alter, for better or for worse, its form.) *By the end of adolescence a sufficiently definite personality structure has been established for us to recognize the characteristic ways in which both ordinary and extraordinary situations are likely to be met and dealt with.*

Thereafter, as the individual's emancipation from parental dependence is achieved, and his establishment as a mature adult realized, *the full flowering (or stunting or warping) of his personality development can be described in terms of*

(a) *his characteristic adjustment pattern, or personality "type,"*

and

(b) *the prevailing environmental situation in which he is immersed and involved,* including the particular, persistent stresses.

Assuming, now, that his adjustment capacities have been overtaxed that he is "ill" (*i.e.*, in the status of "a patient") one seeks to discover

(c) *the critical, overtaxing events (in the outside world) which* have brought about a state of internal tension too great for mastery by means of the patient's characteristic devices; *this may have been because of special vulnerability* which can be related to (a) above

(d) *the emergency measures, internal and external, which have been called upon to deal with the disequilibrium*

and

(e) *the net results of the existing maladjustment in the way of damage and disability.* This means the physical, chemical, psychological and social manifestations of "the present illness."

To apply this formula to a particular case, the psychiatrist should review his historical and examinational data, and organize them for study under a set of connected headings, somewhat as outlined on the next page. This schema can be useful in *thinking through* the material. Every factor must be considered, although in formulating the case a hierarchy of relative importance must be kept in mind, which means *emphasis* and *de-emphasis* or *omission.* Otherwise, details will obscure rather than reveal the case; the trees will hide the forest.

I. *The Personality Development and Structure*

A. Heredo-congenital Nucleus of the Personality.

What hereditary or congenital factors known to have been present have (a) certain (b) presumptive or (c) possible relationship to

the present illness (*i.e.*, to the patient's vulnerability or reactions)? What hereditary or congenital factors discovered by the history seem to bear any certain, presumptive or possible relationship to the present illness? (The relationship may be to the patient's special vulnerability or to the type of reactions appearing in the present illness.)

B. The General Conditioning of Childhood.

Some factors such as the socio-economic status of the family, the attitudes of the parents toward the birth of the patient, etc. may belong to the congenital nucleus, or may become most apparent during the patient's childhood. In general what is wanted here is mention of any psychological or medical or social events which definitely colored the early childhood; this always includes sibling relationships, what kind of a family, what kind of a childhood, etc., insofar as those can be seen to bear a presumptive or clearly established relationship to the present illness.

C. Special Conditioning of Childhood.

What special traumatic factors, forces or events are known or presumed to have modified the childhood development, and how may they be related to the present illness?

D. Data of the adolescent period relevant to the present illness, in point of

1. Physical development—acceleration or retardation, illnesses, operations, embarrassing blemishes, etc.
2. Sexual development, physical experiences (menstruation, masturbation, emissions, hetero- and homo-sexual experiments) and the patient's reactions thereto.
3. Interpersonal relationships within the family and outside, including idealized and inspiring figures and specially hated or ambivalent held figures, with whom some identification was made.
4. Social and sociological factors such as rejection, memberships, popularity, poverty, religion.
5. Educational continuance.
6. Sublimatory opportunities and patterns including work and play habits, hobbies, interests, etc.
7. Relations to property, money, pets, art, nature and other non-human objects.
8. Goals, if known, fantasies, aspirations, idealism, or the reverse.

E. Maturity.

1. What physical illnesses, accidents, operations, etc., have occurred that bear any conceivable relationship to the present illness?
2. What were the continuances of his interpersonal relationship patterns (*i.e.*, friends, attitudes toward employers or employees,

etc.) as related to the present illness? Presumably this interpersonal relationship pattern will be seriously affected by his present illness, to be described later.

3. What was the continuance of the psychosexual development (spouse? progeny?) and with what satisfaction?
4. What have been the prevailing interests in and activities in adult life—*i.e.*, where has he lived for any length of time, how, with whom, doing what, etc. Bring this up to the time of the present illness.
5. What are the patient's customary or characteristic methods of dealing with ordinary stresses and strains? It may be possible to describe this by a conventional "personality type" designation; a short descriptive paragraph is better.
6. What are his characteristic methods of dealing with temporary acute stress?

II. *The Environment*

What has been the (more recent) prevailing environmental situation, *i.e.*, where does the patient live, with whom, doing what, etc.? And against what odds is he working? What satisfactions and dissatisfactions exist intrinsically in his work, marriage, neighborhood, etc.? What does he find especially difficult, unsatisfactory, alarming, threatening?

III. *The Maladjustment*

Consider now what you have found adventitious or extreme in the course of your examinations—physical, chemical, psychological and social. The physical examination may have revealed some damage sustained directly or indirectly—for example, a brain injury, a diabetes, a gastric ulcer, a painful back. The neurological, X-ray and other examinations will supplement this. The social examination may reveal that the environment has been injured in various ways—a "crime," a disappointment, an abandonment, a business failure, a broken home, etc. The psychological examination will describe internal psychological damage and the efforts being made to combat it.

What remains to be done is to establish a chronological and causal relationship between various historical events and the present total picture, and indicate how the present emergent "symptoms" are related to the personality structure and environmental situation described above.

A. What was the straw that broke the camel's back? Was it merely additive, or did it attack a special vulnerability? If the former, what were other, earlier "straws" (stresses and strains)? If the latter, why this special vulnerability? (History.)

B. How much does the patient suffer (in spite of and because of his defense efforts)? (Anxiety feelings, insight and facade.)

C. How is the patient defending himself, *i.e.*, what somatic and psychic reactions to the injury (or threat) are present? Of what order of severity? (Physical examination and psychological examination.)

D. How much does the environment suffer? (*i.e.*, what is the focus and mode of the patient's aggression discharge?)

E. What secondary gains from illness have developed?

F. What is the patient's approach to the psychiatrist and/or hospital, *i.e.*, what attitude toward medical (psychiatric) help and how conditioned by developmental history?

These questions endeavor to assist in describing the picture of maladjustment with reference to the vulnerabilities discovered in the pre-morbid personality development. The object is to be able to say how and why this patient is sick now in this particular way.

IV. *Therapeutic Response*

What you have been describing presumably is the picture of the case at the time the illness had evolved up to a certain point, when the patient came under your observation and treatment. Some changes have certainly occurred since then. These may be clearly reactions to the examinations and treatment or simply metamorphoses in the course of the illness. After all, coming to the doctor or hospital is in itself an extremely radical change in the environment. The patient's reactions to this event and to the new faces and figures in this new environment (doctors, other patients, nurses, aides, others) are of diagnostic and therapeutic importance. They indicate patterns, they suggest revisions in the case analysis. The examinations given the patient, the attempts at making contact with him, the little things done for him—all these are intended to encourage him in the relaxing of overwrought defenses and the concomitant internal distress. The patient's reactions to these initial efforts offer evidence as to the ease and degree of modifiability or reversibility of the illness.

V. *Diagnostic Summary*

No one is satisfied with our nomenclature. It has just been revised, officially, for about the hundredth time (May, 1951). But inadequate as *nomens* may be, they serve as useful index tabs and are necessary for administrative and statistical purposes. Do not be too squeamish or picayunish, therefore, but try to indicate the official medical desig-

nation of your patient's case according to prescribed rubrics, using this schema:

A. Personality type.

B. Psychiatric Syndrome. (Use American Psychiatric Association diagnostic terminology, Veterans Administration diagnostic terminology, locally preferred diagnostic terminology.)

C. Medical, surgical, and dental complications. (Use standard nomenclature.)

D. Unclassified symptomatic manifestations not included above.

E. Sociological status, including economic situation. (No standard terms exist.)

It is required in many places to add to the name-diagnosis of psychiatric illnesses the following:

(1) Brief description of syndrome, severity, and duration
(2) The precipitating stress ("critical overtaxing event")
(3) Degree of predisposition recognized in the premorbid personality
(4) Degree of incapacity.

If no clear diagnosis can be made (which occurs frequently and lies in the nature of many behavior disorders), discuss the differential diagnosis and state procedures which may help to clarify the situation. If several senior staff members disagree on the diagnosis, state such disagreement. Our staff seldom "argues" about descriptive diagnoses. We are mainly concerned with the understanding of dynamic and genetic patterns, predictions and planning of treatment. Some of us, including the author, eschew the meaningless terms "neurosis," "psychoneurosis," "neuropsychosis," "psychosis," "psychopathic personality," etc. as unnecessary and misleading.

ADMINISTRATION—A POINT-OF-VIEW FOR PSYCHIATRISTS

By IRVING SHEFFEL*

The psychiatrist who performs all or part of his work by influencing the behavior of other workers is functioning as an administrator. He has entered a new field which requires the application of a body of knowledge not included in his psychiatric training. In the same manner that he has learned to apply psychiatric techniques to the treatment of sick patients, he now is required to learn administrative techniques in order to build cooperative working relationships.

Many psychiatrists occupy positions where they have both professional and administrative responsibilities. As a ward doctor the psychiatrist may spend only a small proportion of his time working through other employees. As a hospital superintendent or clinical director he may have relatively little contact with patients. In either situation skill in the practice of administration will prove valuable. The extent to which the psychiatrist practices his specialty through the medium of others is increasing rapidly—owing to the development of new sub-specialties and adjunctive techniques.

Many of the responsibilities frequently assigned to doctors in a medical organization can be delegated to laymen who are skilled in administration. Since the psychiatrist has spent many years studying medicine and psychiatry, it is both a loss to society and a personal sacrifice if he then spends much of his time in activities which do not require his professional knowledge and for which others may be better equipped. Hence a knowledge of administration will be useful to the psychiatrist in performing his own immediate job, in determining which elements of the medical organization's work can be shared with others not trained in psychiatry, and in deciding how best to delegate work to subordinates.

Broadly speaking, the administrator's role is to influence the behavior of people in groups so that they will work together cooperatively in defining and accomplishing their group goals, at the same time providing maximum satisfaction to each individual in the group. To develop skill as an administrator one should have an understanding of basic concepts and techniques which have been developed by successful administrators and research workers in the various professions concerned with human behavior.

The psychiatrist will find that there are some similarities between the practice of administration and the practice of psychiatry. For example, the

* Executive Assistant, Education Department, The Menninger Foundation. Formerly Budget Analyst, Hospital Branch, U. S. Bureau of the Budget; Organization and Methods Examiner, Department of Medicine and Surgery, Veterans Administration; Finance Officer, U. S. Army; Inspector, U. S. Wage and Hour Division.

administrator spends a considerable amount of time listening to complaints and attempting to understand what feelings are being communicated to him by the complainants. He knows that the literal statements are often not to be taken at face value, and that interpretations of these are required. This practice of "reading between the lines" is familiar to the psychiatrists. The administrator also knows that considerable patience is necessary while waiting for an organization to change its behavior, and oftentimes he concludes that little change is to be expected because of the influence of certain key personalities who set the behavior pattern for the group. In like manner, the psychiatrist has learned to be patient while waiting for changes to take place in the behavior of individuals whom he is treating. Both the psychiatrist and the administrator recognize that a person does not change a deep-rooted personality trait because he is directed to change it.

There are basic differences, however, between the administrative and the psychiatric approach to people, which create difficulties for the psychiatrist when he functions as an administrator. A major difference is that the administrator's thinking is *group-centered* rather than individual-centered. The administrator looks upon the group as a unit and focuses his attention on the interaction between all members of the group as it affects the group well being. When he acts with relation to any single member he asks himself how his action will affect all the others. The psychiatrist is more inclined to isolate the individual from the group and act toward that individual without considering the effect of his action on the total group.

The administrator's concern with the individual has to do with *how he performs his job and gets along with his fellow workers.* He does not look very deeply into motivations in search of neurotic tendencies. The psychiatrist, however, has been trained to think in terms of personality pathology. He may reduce his administrative effectiveness if he does not restrain his tendency to look for personality defects in an employee even when the employee is functioning satisfactorily on the job. He may find himself attempting to treat the employee as though he were a patient.

The administrator has learned that workers are happier and more productive when *they feel they are respected and are being given responsibilities commensurate with their abilities.* They like to be asked for their opinions and to share in the making of plans and decisions. They appreciate working in an atmosphere where their actions are not too narrowly controlled, and where initiative is encouraged. The psychiatrist probably would agree that such an atmosphere is desirable. However, the psychiatrist is also a doctor, and as a doctor he has learned that he should not delegate his responsibility for making decisions about diagnosis and treatment of patients. He may

ask for advice about treating a patient, but he makes the final decision. He does not meet with a group to vote on whether the patient should be given an operation. If he tells the nurse to give the patient a specific amount of medication at a certain time, he expects her to do exactly this. When the psychiatrist, as administrator, meets with employees to discuss how a letter or report should be prepared, he may find it difficult to break with his habit of giving definite orders. He may not feel comfortable in the role of one who stimulates others to think and make decisions.

The skilled administrator who has worked with different groups and professions realizes that *each has its own status system and code of behavior.* They also have definite feelings about their position in relation to each other. The administrator's consciousness of sub-group loyalties influences the manner in which he introduces changes. If he realizes that arriving at work a half-hour late is an important symbol of status to doctors, he does not think lightly about changing this custom. If the size of an office is recognized as a symbol of importance, he does not move a person from a larger to a smaller office without serious consideration. The psychiatrist new to administration may respect these symbols as they relate to his own profession, but unless he also respects them in relation to the other groups of employees he may unwittingly create disturbances and increase the anxieties of members of the other disciplines.

The finance clerk, the personnel technician, the budget analyst, the supply officer, the maintenance worker, and the countless other non-medical staff members in the hospital do not always see how their actions relate to patient care. They are not in direct continuous contact with patients. One of the most important tasks of the hospital administrator is to help these employees secure an understanding of their importance in the treatment of patients. In order to do this the administrator must have some understanding of their methods of thinking, their values, their status systems, and their goals. Through his actions he can prove to them that he respects them as important contributors to the development of a therapeutic atmosphere in the hospital.

What should the psychiatrist know about administration? Obviously he can not be expected to study administration with the same diligence as a professional administrator. The psychiatrist already has mastered one body of professional knowledge, and unless he has decided to make administration his career, it is unreasonable to ask him to devote the major portion of his time and effort to its study.

The psychiatrist can become acquainted with the general approach of the *administrative generalist*, the mature administrator who has an overall understanding of the various administrative processes. The psychiatrist can learn the basic concepts which serve as guide lines to the skilled adminis-

trator. Whether the psychiatrist can then translate these concepts into action depends to some extent on his flexibility in developing new habits and attitudes which may differ from those required in his therapeutic work.

In order to understand and apply broad concepts of administration the psychiatrist should distinguish between the administrative generalist and the administrative specialist or technician. The latter is proficient in one or more administrative areas such as accounting, job classification, time and motion study, budget analysis, or statistics. Because he usually does not understand his relative place in the organization, he tends to overemphasize the importance of his function and often obstructs those who are responsible for making policies. The common misconception that administration consists mostly of "red tape" and "paper work" results in part from the demands upon the organization made by the administrative specialists and technicians.

The generalist in administration usually has had broad training including experience in a number of the specialties. The generalist attempts to understand the thinking and methods of the various specialists so that he can communicate with them. He also studies the purposes of the organization. If he is in a psychiatric hospital, he attempts to learn enough about psychiatry and the people working in psychiatry so that he can communicate with them. His role then becomes that of a "bridge" between the administrative specialists and the psychiatric specialists. Since direct contact between the psychiatrist and the finance officer may be futile because neither can tell the other what he wants in terms that the other understands, the administrative generalist attempts to do the translating. If he is allowed freedom and flexibility in this role, he can contribute significantly to the smooth operation of the organization.

The following list of concepts useful to administrators is suggested to psychiatrists as a framework for thinking about administrative problems.

1. Administration is concerned with people, not paper.

The important problems confronting the administrator are related to the attitudes and habits of people—not correspondence, not forms, not budgets, not memoranda, not procedures, nor any mechanical gadgets. Administrative tools are valuable only insofar as they can be used effectively to influence the behavior of people. The tools are not ends in themselves, and they can be used to destroy as well as to build. They cannot be evaluated without reference to how they are affecting habits and attitudes of people. A memorandum announcing a salary increase may make people more loyal or less loyal to the organization, depending on how the memorandum is written and how the amount of increase compares with what the workers think they deserve. A new procedure requiring that all reports be

prepared in four copies instead of two copies may have very good justification, but if it is not explained properly it may lead to resentment and refusal to cooperate.

Once he recognizes this basic principle, the administrator usually spends more time deciding *how and when to introduce a change* in the organization than he does deciding what the change should be and how the directive should be written. He may write very few communications, but he will spend a great deal of time talking with people and encouraging them to change their attitudes and habits. Failure to pave the way in advance leads to the filling of waste baskets and file cabinets with directives that have had no effect on behavior. As Simon[8] has observed, "No plague has produced a rate of mortality higher than the rate that customarily afflicts central-office communications between the time they leave the issuing office and the moment when they are assumed to be effective in the revised practice of the operative employees."

The administrator leans heavily upon informal methods for influencing behavior—luncheon meetings, informal discussions, casual conversations, telephone calls, etc. He spends considerable time evaluating prevalent attitudes and may postpone issuance of a new directive until he judges that its chances for acceptance are improved. Barnard[1] has attempted to analyze the conditions required for acceptance of a communication:

> The necessity of the assent of the individual to establish authority *for him* is inescapable. A person can and will accept a communication as authoritative only when four conditions simultaneously obtain: (a) he can and does understand the communication; (b) *at the time of his decision* he believes that it is not inconsistent with the purpose of the organization; (c) *at the time of his decision*, he believes it to be compatible with his personal interest as a whole; and (d) he is able mentally and physically to comply with it.

This emphasis upon considering attitudes of workers is relatively new in the literature of administration. The relationship between attitudes and worker productivity was dramatized by the results of the Harvard University research studies at the Western Electric Company between 1927 and 1932. The research team expected to find that when conditions of work were improved production would rise, but they were startled to find that when conditions were made worse production also rose. Upon further investigation it was found that the attitudes of the workers participating in the experiment had changed during the experiment—attitudes toward each other, toward their employer, and toward their work. Members of the experimental group suddenly felt very important as people because management was taking so much interest in them. The effects of this change in attitude made it impossible to draw valid conclusions about the effects of

variations in illumination, rest periods, length of the work day, and other specific adjustments in working conditions.

2. Duties and responsibilities should be clearly defined.

Every effort should be made to define the role of each individual and each unit within the total organization. The process of arriving at these definitions involves securing agreement on the goals of the total organization and the contribution expected from each member. It is necessary to determine the relative position of each individual and each group of individuals, and to state clearly the assignment of responsibility for each element of the organization's work. Without such clear definitions confusion is inevitable. The hospital aide should know whether his immediate supervisor is the charge aide, the nurse, or the doctor. Where different aspects of the individual's work are supervised by different individuals the dividing lines should be "spelled out." It is not sufficient to state these distinctions on paper—they must be understood by the workers to be effective.

The usual method of picturing the flow of authority and division of work within the organization is through the *organization chart*, summaries of each unit's functions, and descriptions of each job. Although these formal documents generally remain static for long periods, job performances and relationships between employees are changing continually. As individuals within the organization change positions and new employees arrive, variations occur in the flow of authority. Many factors besides their job descriptions influence the manner in which people function within the organization —feelings about superiors and subordinates, personality traits, previous training and experience, skill in communicating, personal interpretations of the group goals, etc. No two individuals exercise the same authority if given the same position. Therefore, while the administrator should not abandon his effort to obtain clear definitions of authority, he should not expect complete adherence to the formal organization chart. In his daily operations, if he is to be effective, he should also utilize the *informal* aspects of relationships within the group—who talks to whom, who listens to whom, who are the natural leaders, what are the symbols of status, who is energetic and ambitious.

3. Conservation of organization energy is a problem of administration.

The organization at any one moment possesses a definite quantity of human and material resources. The administrator is concerned with the efficient utilization of these resources. He uses various techniques for analyzing how human energy and materials are being spent and for re-

ducing the amount of waste. Among such techniques are the charting of work procedures, the elimination of forms and reports that are not serving useful purposes, and the evaluation of results produced by committees and group conferences. Vast quantities of unnecessary reports and forms are found in any organization where there is not constant scrutiny of this activity. These create a severe drain upon the energy of the organization. An administrative officer who recently joined the staff of a medical clinic was able to eliminate over 50 forms within a few weeks when he questioned the usefulness of each form and found that they were not providing any information that was helpful in making decisions about current operations or future plans. He developed a simplified form and report that provided information of great value for decision making and saved countless hours of time for both professional and clerical workers.

4. The equilibrium of the organization is constantly threatened.

The administrator knows that within his organization exists a continuous "tug of war" between different factions and individuals. Many factors contribute to these undercurrents of conflict—personality differences, competition for power and status, differences of opinion over policies and goals, loyalties to professional creeds that overshadow loyalty to the organization, over-identification with limited aspects of the work, lack of accurate information flowing through the group to combat false rumors, and many other conditions prevalent in organizations. In the midst of these persistent threats to unity that undermine and may even destroy the organization, he charts a course that he hopes will bring out the beneficial aspects of conflict and minimize its damaging effects.

Changes within an organization and pressures from the outside have their effects upon the equilibrium of the organization, and the administrator must learn to evaluate these effects. National and international developments, turnover of personnel, changing emphasis upon the importance of various functions, and passage of time all influence the habits and attitudes of individual members of the group and relationships between the different members. An increase in the salary of one member may increase his feelings of loyalty to the organization and at the same time decrease the feelings of loyalty of ten others who feel they also deserve an increase. A promotion may have a similar effect. The injury of a patient by a psychiatric aide, followed by a wave of suspicion against all aides, can immediately cause the best aides to feel threatened and less loyal to the hospital management. A new research development may threaten the security of many workers. Increased family responsibilities and worries may decrease the efficiency of a worker. While it is not possible to consider all such factors in making

decisions, the alert administrator is aware of them and attempts to predict what changes in group equilibrium will take place when he plans a specific move, at the same time taking precautions to reduce adverse effects.

5. Communication systems require continuous attention.

How to develop effective communication within an organization is one of the major concerns of the administrator. He finds that many people give lip service to the idea that good communication is important, but their practices vary considerably. Too often, emphasis is placed on handing information down from higher authority without much effort to secure a free flow of information from the lower to higher levels. The exchange of information between different departments and horizontally across the different levels is also neglected. In addition, there is too much attention to the communicating of facts and figures and not enough interest in communicating *ideas, attitudes, and feelings.* Many communications from above have an effect opposite to what is expected because of this failure to understand the feelings of those on the receiving end. Gardner[2] has described some of the vicissitudes of communications going up and down through the organization:

> Because of the nature of the man-boss relationship, because each person is so dependent on his boss for communication and recognition up the line, because each person is so sensitive to his boss's moods, opinions, likes, and dislikes, there is often much confusion and misunderstanding in communication down the line. Since everyone below him is constantly trying to anticipate his wishes, trying to read his every word and gesture, the boss does not always have to put into words his ideas and what he expects of the job. But as a result of this extreme sensitivity to the boss, there are in any work situations frequent misinterpretations, and the problem of impressing the boss sometimes becomes more important than getting the work done.
>
> At the same time, and also because of their sensitivity to the boss and their dependence on him, there is a good deal of distortion of the facts in communicating up the line. Along with a great concern for 'giving the boss what he wants,' there is a constant tendency to 'cover up,' to keep the boss from knowing about the things that go wrong or the things that do not get done. No one wants to pass bad news up the line, because he feels that it reflects on him. . . . In this way people at each level develop methods of defense, often complicated and ingenious, by means of which they protect themselves from criticisms from those above.

The techniques for improving communication are many—meetings, supervisory conferences, house organs, memoranda, bulletins, social affairs, physical arrangement of offices and desks in relation to each other, etc. When these techniques are applied with proper understanding of what they

are designed to accomplish they can be very effective, but when introduced in a ritualistic or mechanical manner they often defeat the purpose intended. The administrator should develop sensitivity to the feelings which lead to the communications he receives and not handle them as literal statements. If he is told by one of his colleagues that the organization chart should be revised, this could mean many things, such as the following: "My salary is too low," "I don't have enough status," "I feel insecure here," "We must figure a way for getting around someone in authority who is not doing a good job." While it is true that the organization may need a change, it may very well be that the change may not bring to the person recommending it the goals he is seeking. Unless the administrator has some awareness of the motivation behind the recommendation he will make decisions that do not bring the results he expects.

6. To what extent can leaders be trained?

Any analysis of major concepts which shape the thinking of the administrator, even one as brief as this, would be incomplete without some mention of leadership. The more experienced the administrator, the more he realizes that individuals vary in their capacity for developing skill in influencing others. On an empirical basis practical administrators have learned that it is difficult to teach a person how to supervise unless he has certain personality traits which make it possible for him to secure the voluntary cooperation of those working under him. Among the desired traits are emotional maturity, skill in dealing with other people, ability to listen as well as to talk, courage to make decisions, and the power to inspire subordinates and associates.

It is possible to teach the supervisor techniques which will help him to develop his skill to a certain point, but his *basic personality and feelings of security* determine that limiting point. Recognition of this fact is a discouraging aspect of the administrator's work because it often means that he either must remove a supervisory official or content himself with inefficient operations if the supervisor is unable to practice the techniques of good supervision. Many supervisors know all the important principles of supervision and are able to express them verbally, but are unable to practice them.

The qualities which the leader should possess are not the same in all situations. A leader who is effective in a rapidly changing organization might demoralize a group that has a relatively stable set of functions. Too often the leader is selected on the basis of a single qualification—his competence as a worker or his length of service. When this is the sole criterion the organization often loses a good worker and acquires a poor supervisor. Those people who command respect for their skill as workers and also have

the ability to supervise make excellent leaders, but unfortunately the two capacities do not always go together.

Understanding the philosophy and techniques of good administration will help the psychiatrist work toward improvement of his own administrative skills and also will help him decide how he can share his responsibilities with laymen trained in administration. If the psychiatrist is able to recognize men who have the capacity for exercising authority wisely and competently, and if he can permit such men to take responsibility, he will find that he can devote more of his time to his patients.

BIBLIOGRAPHY

1. Barnard, C. I.: *The Functions of the Executive*. Cambridge, Harvard University Press, 1945.
2. Gardner, B. B.: *Human Relations in Industry*. Chicago, Richard D. Irwin, 1947.
3. Glover, J. D. and Howers, R. M.: *The Administrator—Cases on Human Relations in Business*. Chicago, Richard D. Irwin, 1949.
4. Leighton, A. H.: *The Governing of Men*. Princeton University Press, 1945.
5. Mayo, Elton: *The Social Problems of an Industrial Civilization*. Boston, Harvard University Graduate School of Business Administration, 1945.
6. Roethlisberger, F. J.: *Management and Morale*. Cambridge, Harvard University Press, 1946.
7. Roethlisberger, F. J. and Dickson, W. J.: *Management and the Worker*. Cambridge, Harvard University Press, 1939.
8. Simon, H. A.: *Administrative Behavior*. New York, Macmillan, 1947.

CHRONIC PSYCHOSIS AS A SEQUEL TO MEASLES ENCEPHALITIS*

By WILLIAM S. SIMPSON, M.D.†

Much has been written about the acute stages of measles encephalitis, but very little has been reported about long-term sequelae, particularly those of chronic mental disorder. The author has had the opportunity of closely studying the clinical history and present condition of a 53 year old woman who developed a psychosis coincident with a severe attack of measles encephalitis at the age of 16. The psychosis has recurred intermittently over a period of 38 years. Review of the literature reveals no full clinical description of psychoses following measles encephalitis.

Case Report

The patient was the 12th of 13 siblings in a mid-western, middle-class family. Very little is known about her premorbid personality. She had been a good worker, of "normal make-up, not inclined to worry and not stubborn," and had always been a healthy girl. She had quit school in the eighth grade at the age of 15. There was no history of mental disease in the family.

The patient was first admitted to Topeka State Hospital April 29, 1913, at the age of 16. Seven weeks prior to her first admission she developed chicken-pox, recovering in one week. Eight days later she developed measles, and until a few days before admission, had a temperature of 103 to 104 degrees and was "delirious, even before the rash appeared." Her physician suspected meningitis complicating the measles. At home she refused food and medicine, had insomnia, was restless and seemed disoriented. She was hyperactive and had mood swings. She showed negativism at times, and echolalia. Physical examination showed her to be thin, pale, of small stature, and with sordes on her lips. Chicken-pox scars were on the face and abdomen. Pulse was irregular and so rapid that its rate could not be determined with certainty. The lips were bluish, and expression was pinched. Knee jerks were absent. The pupils were equal in size, regular in outline, and reacted normally to light. She was in a state "approaching collapse."

She was tube fed for five weeks and given neutral baths for insomnia and restlessness. She was weak at first and had purposeless movements of the limbs. After regaining some strength, she became periodically active, with "stunty actions," some of them of a stereotyped character. She was occasionally noisy, and used vulgar words, but without any apparent feeling. Her hands were restrained to prevent masturbation. She was untidy. She climbed the walls and dangled her feet in the toilet. She was quiet at times and at other times sang in a loud harsh voice. About 10 weeks after admission she began eating heartily, gained weight, and slept well. Her consciousness appeared to be clouded, she was disoriented for time and place, and her remarks were disconnected and inconsequential. Echolalia, echopraxia, rhyming, stereotypies, and irrelevant answers to questions were noted. She often turned quickly until dizzy,

---

* Case Report from Topeka State Hospital.

† Fellow, Menninger School of Psychiatry, Topeka, Kansas.

and at other times assumed awkward postures. Automatic obedience was noted. She was indifferent or mildly happy, and occasionally cried loudly without appropriate facial expression. She had no insight.

For seven weeks thereafter she continued to be as described, but at the same time she was gaining in strength and health and very gradually improving in "conduct." Hydrotherapy seemed beneficial. By October 22, 1913 she had gained 28 pounds, had cleared up mentally and no residuals were in evidence. She was described as a willing worker, using good judgment, and conversing intelligently. Her memory was good except for the period of acute illness for which she had no clear or accurate recollection. She was diagnosed "dementia praecox, catatonic type," paroled October 22, 1913 and discharged "restored" January 27, 1914.

After discharge she was said to have been "off" several times, talking very little or not at all for as long as a month at a time, but at other times seemed perfectly well.

Subsequent Course

She married in 1919, immediately became pregnant and when eight months pregnant suddenly experienced another psychotic breakdown, with delusions of influence. She had visual hallucinations, but no auditory hallucinations were noted. She was hospitalized privately in August, 1920. At this time she was extremely hyperkinetic and destructive and had to be restrained. She talked loudly in a hoarse voice, and the speech was intermittently coherent. She spoke baby talk a good deal, saying that she was only three years old. She slept little and had outbursts of rage. She was very excited, but not elated. Her attention was easily gained, but could be held only for a moment. A provisional diagnosis of "schizophrenia catatonica" was made.

She was transferred to Topeka State Hospital in September, 1920, after giving birth to a stillborn child. Physical examination showed sacral pressure sores, internal strabismus of the left eye, right pupil larger than the left, absence of knee jerks. Pupils reacted to light, both directly and consensually, and to accommodation. Further examination could not be done because she would not cooperate. She was inaccessible to questioning, chattering continually, never still, constantly jerking her body or moving her hands and feet even when sitting or lying in bed. Her speech was slurring on admission, but improved in time. Attention and comprehension were very poor, her stream of thought was incoherent, irrelevant, and rambling. A month after admission the knee jerks were found normal. She weighed only 95 pounds and had to remain in bed for several weeks. She was very confused, but pleasant and agreeable. She gained about 40 pounds by March, 1921, and rapidly improved mentally. She was diagnosed "manic-depressive, manic type," and was paroled April 23, 1921. Within the next year and a half, she gave birth to a daughter. Delivery was apparently normal.

On July 6, 1922, she voluntarily returned to the hospital, complaining of loss of weight, nervousness, and weakness. She was fearful of becoming ill again, but showed no psychotic symptoms. She felt better after treatment with hydrotherapy, and was again paroled, October 3, 1922. The psychiatrist wrote at that time that she was of a "somewhat unstable, nervous type. Any undue stress she might have to undergo may result in future attacks."

She was again admitted in April, 1926. During the preceding six weeks at home she had exhibited continuous incoherent talk, nervousness, excitability, and was uncontrollable. She believed that her husband was unfaithful. No notes are available about psychological tests regarding her mental status at that time. From 1926 until 1936 she was in and out of the hospital five times, spending a total of four years out of

the ten in the hospital. She was divorced in the latter part of this period. She was discharged as improved while on parole in 1936.

She was re-admitted in January, 1937 "in a manic state," noisy and distractible. Orientation was good, memory for remote events good, but memory for recent events was hazy. She showed marked flight of ideas and some exaltation. She showed no signs of delusions, but lacked insight. She was extremely active, tearing up bed clothes, etc. From the time of admission until 1949, progress notes indicated that she remained continuously in a "chronic manic state," becoming "progressively worse," "showing mental deterioration." She was destructive, noisy, untidy, annoying to other patients, and had to be almost constantly confined to the seclusion area. In September, 1949, due to her agitated and hyperkinetic state, she ran a temperature from 102 to 105°F. Conservative measures failed, she obtained no rest from her agitation, so in November, 1949, she was given 10 Electro Convulsive Treatments (ECT's). The results were excellent. She was transferred to a quiet ward, went on walks, assisted with making curtains, and was visited by her daughter, who was amazed at the change. The patient remarked that she was surprised that she had "been here two years this time." However, on seeing a fight between two other patients on the ward, within a matter of hours she regressed to her former status and was transferred back to the disturbed ward. She improved following 11 more ECT's given in December, 1949, and January, 1950, but she rapidly regressed again. The diagnosis was still manic depressive psychosis, manic type.

The writer first saw the patient in July, 1950. She was middle-aged, of medium height, muscular, wiry, and disheveled in appearance. Being almost constantly in motion, she was covered with minor bruises and lacerations from bumping into objects. She walked with a rather peculiar loping gait, knees and hips slightly bent, and the feet wide apart. She picked up all sorts of trash from the floor, either holding it in her hands or stuffing it in a handbag. This behavior along with extreme distractibility and a euphoric air gave her a strong resemblance to a circus clown. She was quite affectionate toward the examiner, often trying to make gifts of trash to him, or walking down the ward with her arms about him. Though it was difficult to make out her continually mumbled, singsong, scanning type of speech, when placed in a sheet pack, she quickly relaxed and, while still retaining its scanning quality, her slowed speech became intelligible.

Her thought content was centered mostly on her desire to go home to her family. She gave no evidence of thought disorder, delusions or hallucinations. At this time deep reflexes and the pharyngeal reflex were absent. Electro-encephalogram (EEG), electrocardiogram, chest and skull X-rays were normal. Blood Kahn test and cerebrospinal fluid were normal also, as were other routine laboratory tests. Because ECT had formerly been effective in quieting her, she was given ECT in August and September, 1950 and again showed a marked change for the better. She became normal in her movements, though she often maintained rather bizarre and grotesque postures while sitting down. The scanning speech remained and she appeared somewhat depressed, discouraged, and dejected. At this time she

was again transferred to a quieter ward and psychological tests were given. The test picture showed confusion, distractibility, difficulty in comprehending test instructions, and considerable weakness in psychomotor functioning. She seemed to be able to perceive or copy only the most simple design, and her actions were random and confused and apparently unrelated to the design she was to copy. Her drawings of a person were likewise gross and showed motor difficulty even when she perceived the Gestalt correctly. This implied that the difficulty was primarily motor and not in either visual or mental perception of the designs. Her IQ on the Wechsler-Bellevue was 72 but her potential was probably in the low average range. The patient was in the middle of a reaction to ECT and these organic signs were at that time referred to this cause.

On September 29, 1950 she was presented to a conference where the possibility of measles encephalitis was discussed in the light of the history and the absence of deep reflexes. A more thorough neurological examination revealed the following findings which supported the diagnosis of measles encephalitis: flattened facies, infrequent blinking, slightly slow gait, poverty of associated movements, mild ptosis of the left face with flattening of the left nasiolabial fold. All movements were slow, and she was unable to accomplish fine and rapid alternating movements. All deep reflexes were sluggish, and the superficial abdominal reflexes were absent.

Between August 10, 1950 and August 23, 1950, she was given seven ECT's at thrice-weekly intervals. Between October 25, 1950 and December 18, 1950 she received 17 ECT's, at the rate of three times weekly, and was able to maintain a marginal adjustment. At the same time, ward personnel spent a great deal of time with her, offering companionship and encouraging her to relinquish her peculiar bodily postures, with limited success. Plans were discussed with her for a week's visit at her daughter's home, beginning December 22, 1950. However, a few days before her expected departure, she began to regress to her hyperkinetic state, and a day before her scheduled visit it was necessary again to transfer her to the disturbed ward, where she has remained since, presenting the same picture as mentioned previously.

The Block Design subtest of the Wechsler-Bellevue was given again in April 1951 (3½ months after last ECT). The patient's distractibility, rambling, and inability to concentrate on the tests precluded complete testing. She showed almost the same inability to deal with any but the most simple designs. There was some expression of irritability and she gave up when she could not proceed further. The performance was suggestive of organic brain damage but nothing definite could be concluded due to the fragmentary nature of the tests given.

Review of the Literature

Ford[1] in discussing chickenpox encephalitis, noted that the clinical picture and pathological findings of this disease are almost identical with that of measles encephalitis, though the former condition is much more rare and generally more benign. Encephalitis due to chickenpox occurs within three to fourteen days following the appearance of the rash, while encephalitis due to measles may occur from before the rash appears to about 14 days after.

Several reports of the chronic psychiatric and neurological sequelae are available. On the basis of cases which he followed from five to ten years, Ford[1] noted that mental changes were the most common of all, occurring in one-third of his cases, usually consisting of slight reduction of intelligence, more or less irritability, and instability of mood. Neal[2] reported two cases of mental deficiency, and one behavior disorder (having a history of stubborness, truancy, stealing, poor school work, restlessness and impulsiveness). Neal and Appelbaum[3] reported a case of a five year old boy who remained a mental defective. Hamilton and Hanna,[4] in a review of 285 cases collected from the literature, report "psychosis" in nine cases, but no details of the psychoses are included. Ford[5] in a masterly monograph, noted that during convalescence, transient mental disturbances are common and prolonged toxic psychoses may occur. Ford cited cases reported by Sotow (*Jahrb. F. Kinderh.* 50: 1–14, 1899) who published 11 cases of this nature. These included Chatelani, who described a case with manic and depressive features in a girl of five years; Kraepelin, who mentioned delirium with auditory and visual hallucinations in a girl of 13, and excitement with delirium in a boy of six years, whose sister, ill at the same time, was depressed; and Finkelstein's patient, a boy of 13 years, who showed delirium and terrifying hallucinations. Kowalewski observed depression and delirium in a boy of 11 years. Sotow's own case was that of a four year old boy who had much clouding of consciousness with hallucinations and excitement. Ford claims that these are all toxic-delirious states with more or less affective coloring, that the patient's premorbid personality plays an important role, and that there is nothing specific in the effect of the measles toxin. In the 125 cases Ford reported, 22 showed mental defect. Changes in personality, irritability, emotional lability, destructiveness, and asocial behavior are less common.

Litvak, Sands, and Gibel[6] reported 56 cases with a follow-up in 32. In their follow-up studies the neurologic manifestations tended to disappear with time, replaced with behavior disorders resulting from an injured brain. Psychiatric and neurological sequelae they noted, in order of frequency, were emotional instability, masked facies, loss of all reflexes, Babinski sign,

retardation in school, hyper-reflexia headache, internal strabismus, pallor of optic disks, enuresis, obesity, impaired manual dexterity, tremors, facial palsy, ataxia, choreiform movements, convulsions, petit mal seizures, atrophy of the optic nerve, papilledema, paresis of arm, nystagmus, and scanning speech. They noted no correlation between the severity of the onset of the encephalitis and the prognosis for recovery or sequelae, but they believed that the longer the neurologic signs persist, the more frequent are the sequelae and the more unfavorable the prognosis.

Pathological Findings

The literature is replete with pathological findings in acute cases which came to autopsy.[7–11] Finley[9] points out that in acute encephalitis associated with vaccination, variola and measles, the lesions are perivenous in nature, and are more marked as the veins become larger. This accounts for the fact that most of the lesions seen are located in the white matter of the cerebral cortex, deeper layers of the grey matter, the grey matter particularly of the basal ganglia and nuclei of the brain stem, pons, corpus striatum, thalamus, subthalamus, white substance of the cerebellum, both grey and white matter of the spinal cord, and subependymal layers of the lining of the third and fourth ventricles, as these areas are abundantly supplied with veins. The lesions themselves[8] showed the histological features of an inflammatory process characterized by exudation of lymphocytes and plasma cells, perivascular proliferation of microglia and accompanying degeneration of myelin and axis cylinders.

The only accounts of pathological features of the chronic stage of the disease which came to the author's attention were those of Malamud,[12] who studied two cases. The first, that of a young Mongolian idiot (who developed measles encephalitis associated with residual right-sided pyramidal tract signs) died five years later as a result of miliary tuberculosis. Autopsy showed that the changes characteristic of chronic measles encephalitis were those of widespread perivenous and subependymal demyelinated lesions restricted to the white matter of the cerebrum and cerebellum, and marginal gliosis in the spinal cord. The intensification of this process in the cephalic elements of the centrum ovale and the corona radiata, especially on the left, can be correlated with the neurologic observations. Malamud's second case was that of an eight year old boy who developed measles encephalitis, followed by organic changes and personality changes characterized by involuntary movements of the extremities, increased salivation, restlessness, euphoria, impairment of memory and concentration. Follow-up reports, four months and two years after the initial illness, described him as a hyperkinetic, manneristic and irritable boy with an IQ of 75, mild ataxic gait and incoordination. Death occurred from unknown causes five

years after the illness. Autopsy showed perivenous and subependymal demyelinated lesions in the cerebral and cerebellar white matter and marginal gliosis in the spinal cord. The lesions in both cases were poorly outlined coalescing foci of demyelination, in which myelin sheaths and axis-cylinders were equally destroyed. These were uniformly replaced by dense glial scars devoid of any signs of inflammation, progressive glial activity or an advancing wall.

Discussion

The question arises as to whether the patient described has an encephalitic psychosis or whether she merely has a schizophrenic or manic depressive psychosis which happened to be precipitated by an acute infectious disease. What evidence have we for assuming that the patient has an encephalitic psychosis?

1. The mode of onset suggests measles encephalitis. Our patient initially had a toxic delirium, with restlessness, disorientation, clouded consciousness and confusion, accompanied by high fever, weight loss, and a physical condition "approaching collapse." These symptoms and signs are in accord with what is found in the literature on the acute stage of the disease.[4–6] The disease can be extraordinarily severe in its effects: 20 per cent of the acute cases end in death.[4]

2. The presence of recurrent minor neurological findings is of considerable importance, and cannot be explained on any basis other than organic brain damage. The fact that the EEG is normal in our patient does not exclude the diagnosis of measles encephalitis, as the pathological findings indicate that the lesions are subcortical.

3. Noteworthy in our patient is the absence of thought disorder except during the acute episodes of the illness. At the present time she has no thought disorder; she converses quite rationally and is quite aware of what is going on around her. This tends to exclude a long-standing schizophrenic psychosis. Her general picture at present does not even remotely resemble that which one would expect in a chronic schizophrenic.

4. The intermittent character of the psychosis, finally becoming chronic, does not help us in establishing the diagnosis, as this is in accord with the usual characteristics of a chronic manic psychosis. We are hampered by the lack of literature in regard to measles encephalitis, because to the writer's knowledge, no cases are reported which have been followed over so long a period as this one (38 years). Even now our patient is difficult to classify under any of the standard nosological classifications of psychoses.

5. The findings of involuntary movements of the extremities, restlessness and hyperkinesis, coincide with the findings in one of Malamud's cases which came to autopsy,[12] described above.

6. The chronic mood disorder could be explained on the basis of a chronic manic-depressive psychosis, manic type, or possibly on the basis of encephalitic lesions in the region of the third ventricle and/or hypothalamus. Foerster[13] described a case of suprasellar meningioma in which manic behavior appeared when the tumor was manipulated, concluding that the effects were due to the effects on the floor of the third ventricle. He also found that mechanical irritation of the anterior section of the hypothalamus could precipitate a manic-like picture. Stern and Dancey[14] report a case of chronic mania due to a glioma of the diencephalon.

The foregoing points by no means incontrovertibly establish a diagnosis of psychosis due to measles encephalitis. It is felt, however, that this case report should be published in the hope that it may stimulate others to investigate cases of psychosis which have begun with an episode of measles encephalitis.

BIBLIOGRAPHY

1. Ford, F. R.: *Diseases of the Nervous System in Infancy, Childhood, and Adolescence*, ed. 2. Springfield, Ill., Charles C. Thomas, 1944.
2. Neal, J. B.: *Encephalitis, A Clinical Study*. New York, Grune & Stratton, 1942.
3. Neal, J. B. and Appelbaum, Emanuel: Encephalitis Associated with Measles. *J. A. M. A.* 88: 1552–1554, May, 1927.
4. Hamilton, P. M. and Hanna, R. J.: Encephalitis Complicating Measles. *Am. J. Dis. of Child* 61: 483–493, March, 1941.
5. Ford, F. R.: The Nervous Complications of Measles. *Bull. Johns Hopkins Hosp.* 43: 140–184, Sept., 1928.
6. Litvak, A. M., Sands, I. J. and Gibell, Harry: Encephalitis Complicating Measles, *Am. J. Dis. Child* 65: 265–295, Feb., 1943.
7. Zimmerman, H. M. and Yannet, Herman: Encephalomyelitis Complicating Measles. *Arch. Neur. and Psychiat.* 24: 1000–1013, Nov., 1930.
8. Malamud, Nathan: Encephalomyelitis Complicating Measles. *Arch. Neur. and* Psychiat. 38: 1025–1038, Nov., 1937.
9. Finley, K. H.: Perivenous Changes in Acute Encephalitis Associated with Vaccination, Variola, and Measles. *Arch. Neur. and Psychiat.* 37: 505–513, March, 1937.
10. Ferraro, Armando and Scheffer, I. H.: Toxic Encephalopathy in Measles. *Arch. Neur. and Psychiat.* 27: 1209–1225, May, 1932.
11. Musser, J. H. and Hausser, G. H.: Encephalitis as a Complication of Measles. *J. A. M. A.* 90: 1267–1270, April, 1928.
12. Malamud, Nathan: Sequelae of Post-Measles Encephalomyelitis: A Clinico-Pathologic Study. *Arch. Neur. and Psychiat.* 41: 943–954, May, 1939.
13. Foerster, Otfried: Veber die Bedentung und Reichweite des Lokalisationsprinzip im Nervensystem. *Verhandl. d. deutsch. Gesellsch. f. inn. Med.* 46: 117, 1934.
14. Stern, Karl and Dancey, T. E.: Glioma of the Diencephalon in a Manic Patient. *Am. J. Psychiat.* 98: 716–719, March, 1942.

BOOK REVIEW

Reality and Dream. By GEORGE DEVEREUX, Ph.D. Price $7.50. Pp. 438. New York, International Universities Press, 1951.

From Radin's *Crashing Thunder* to Leighton's *Gregorio the Hand-Trembler* American anthropologists have repeatedly approached culture through a study of personality as seen in individual life histories. The uniqueness of Devereux's work, therefore, rests in its being the first extended document of trans-cultural psychotherapy. Such an undertaking presents special difficulties: there must be, as there is in *Reality and Dream*, a painstaking elucidation both of the ethnographic framework and of analytic theory. Consequently, there is some repetition of the obvious to experts in either, but the gain in methodological clarity is worth the labor.

Were the book only a minute documentation of a "Wolf" Indian personality, this alone would ensure its importance as a sourcebook for an emergent comparative psychiatry. More than this, however, it presents important new orientations for students of culture and personality. Devereux believes that the earliest students in this field have been overly preoccupied with the pregenital conditionings of basic character structure in a group. He contends that it is not alone these pre-oedipal influences upon the infant (mere culture-*trait* pedagogics) that are significant; rather, it is the ethos-provided *resolution of the oedipus* (culture-*patterned* amphimixis) that is prepotent—a viewpoint that undoubtedly adds further range and depth to our understanding.

> "The decisive force in personality formation is the ethos, which gives meaning to discrete culture traits, rather than the individual culture traits, *e.g.*, training techniques, themselves. The determining force of the latter depends primarily on the extent to which they reflect the over-all ethos and pattern of the total culture. This means that the basic personality is formed *primarily* during the oedipal and pubertal periods, *whose resolving eliminates or sublimates earlier pregenital urges.*"

Another interesting theoretical contribution of Devereux is the concept of "areal basic personality."

> "The most important and viable aspect of culture, and, *therefore*, the most significant influence on the formation of the basic personality is the areal culture pattern... the only aboriginal cultural factor which has survived well enough to retain its *functional* significance for personality formation appears to be the areal ethos, and, to a lesser extent, the tribal ethos."

With regard to the Plains area in particular (and perhaps deculturated peoples in general), this reviewer would agree that such an "areal ethos" is certainly behind the rapid Plains-wide diffusion of the Sun Dance, the Ghost Dance and peyotism alike. Thus, *in the present context*, Devereux is undoubtedly right; but the question remains with regard to fully functioning cultures whether obvious tribal distinctnesses are thus derivable (*e.g.*, Arapesh, Mundugumor and Tchambuli are at the very least *distinct tribal phrasings* of an assumed culture-areal ethos). Whatever the dynamic fact, however, this certainly provides a rationale for Devereux's protection of his patient, inherent in his very method, for he can cite ethnographic

data anywhere from the whole northern Plains area without disclosing the tribal identity of his patient.

The acute comments of Dr. Goldfrank add much to the book. The ethnographer will also delight in Dr. Devereux's masterly handling of themes: the Plains guardian spirit as a paternal imago; Plains women as sexual trophies, parts of the male's extended ego or prestige- and security-system (exploitative male sexual activity raises his prestige, but the seduction of his wife and kinswomen lowers it); the "testing theme" in Plains religion; the "manly-hearted women" of the northern Plains; the institutionalized "favorite child"; the the male transvestites or berdaches; the northern Plains water phobia; the therapist's debunking the magic aspects of counselling, whereupon the patient accuses him of undermining the patient's faith in religion; Goldfrank's contention that while rivalry and hostility among males was highly institutionalized and stylized in the Plains, the Plains Indian male was nevertheless also essentially hostile to females, especially in a sexual context, and expressed this hostility in a *direct* manner.

The psychoanalyst will appreciate also Devereux's therapeutic goal: the homosexual sadomasochistic dependency cravings of cultural origin in the patient were not interpreted, as being parts of a basic Plains security system and the source of borrowed ego strength; the objective was the rehabilitation of a "Wolf" personality, not a reconstruction along the lines of basic American character structure.

In its inclusion of Rorschach and other protocols (including a pioneering use of projective technique in finger-painting), the work is meticulously complete; it is also beautifully indexed.

WESTON LA BARRE, Ph. D.
Durham, North Carolina

BOOK NOTICES

The Neurosis of Man. An Introduction to a Science of Human Behavior. By TRIGANT BURROW. $7.50. Pp. 428. New York, Harcourt, Brace, 1949.

For thirty years Trigant Burrow has tried earnestly to communicate certain eclectic concepts regarding human behavior and its social determinants. He believes that the main source of human troubles is to be found in language which serves to divide people rather than to unite them. Presumably to remedy this situation he makes extensive use of neologisms which render this book almost impenetrably obscure and irritatingly exotic. He distinguishes between cotension and cotention, ditension and ditention. He uses hominid to mean human being, phylum to mean the human race, "I" *persona* to mean something like ego, etc. The book is tantalizing (in many respects) because it does contain insightful passages, some of them even lucid, and because it points the way toward valuable concepts of social integration, but the obscurities and the indefinitenesses which still remain are intolerably frustrating. (Louisa Holt, Ph.D. and K. A. M.)

The Meaning and Practice of Psychotherapy. By V. E. FISHER. $5. Pp. 411. New York, Macmillan, 1950.

This reviewer objects principally to the word, "The" in the title of this book. As with possibly all the books on such a subject, this work represents a limited, highly personal approach to psychotherapy. There seems to be little system to the author's method. He attempts to decide in advance what should be the best outcome for the patient and tries to bring the patient to take the necessary steps. The method is eclectic, directive and educational. The author makes rather free use of analytic language without much regard for its classical meaning or for consistency in its use. To analytically oriented readers, this book might be a source of irritation. It offers the usual series of patients receiving benefit. (R. L. Sutherland, M.D.)

Aus den Anfaengen der Psychoanalyse. (Letters to Wilhelm Fliess, Essays and Notices of the Years 1887–1902.) By SIGMUND FREUD. $3. Pp. 477. London, Imago Publ. Co., Ltd., 1950.

These letters from Freud to his friend, the Berlin rhinologist, Wilhelm Fliess, give us a precious insight into the rudiments and early evolution of psychoanalysis. Freud was impressed with the personality of Fliess and with his controversial "theory of periods," although he was not uncritical of Fliess' work. Thus Fliess became Freud's scientific confidant, and these letters reflect the thoughts and courses which led to the extension of psychoanalysis. This process was neither direct nor simple. We recognize that even such a speculative idea as the "death-drive" was influenced by the "theory of periods" in which Fliess had concluded that even death is determined for the individual periodically. But we are surprised and especially impressed, for example, that Freud maintained in a letter written in 1896 that analysis "has already established without any doubt that paranoia really is a defense-neurosis." Generally one gets the impression that Freud had already prepared the concept of analysis in these early years and that its theoretical completion was for him only a question of time and experience.

We have to acknowledge our indebtedness to the editors of this book, Anna Freud, Marie Bonaparte, and Ernst Kris, for this fundamental contribution to the comprehension and development of psychoanalysis. We should not forget the masterful explanatory introduction by Dr. Kris, and the appendix which acquaints us with the "Sketch of a Psychology" (psychology of natural scientific methods), which Freud wrote in this early period. We hope that this important book will become accessible to English-speaking readers very soon. (Robert H. Jokl, M.D.)

Textbook of Abnormal Psychology. Rev. ed. By CARNEY LANDIS and M. MARJORIE BOLLES. $5. Pp. 634. New York, Macmillan, 1950.

This textbook possesses little merit and numerous deficiencies. The authors profess to present an eclectic viewpoint of psychology, but for the most part depth psychology is either ignored or damned. The congenital defect of microcephaly is given more attention and space than the extremely important psychic phenomena of dreams. The utilization of Kahn's

classification, (*e.g.*, eccentrics, trouble makers, senseless criminals, etc.) to present psychopathic personalities is indicative of the uninspired authorship. (William Rottersman, M.D.)

Anxiety. PAUL HOCH and JOSEPH ZUBIN, eds. $4.50. Pp. 254. New York Grune & Stratton, 1950.

These proceedings of the 39th annual meeting of the American Psychopathological Association in 1949 have provided an excellent compilation of current thinking regarding the problems of anxiety from the historical and social, the psychological, the clinical and psychodynamic, and the physiological approach. Such contributors as Lauretta Bender, Sandor Rado, and Ernst Gellhorn have given a rounded out consideration to the pervasive and general symptom of anxiety. The section on physiological approach includes Hans Lowenbach's and Burke Suitt's discussion of alterations of anxiety subsequent to physical treatment of psychiatric disorders. (Leyda Lythgoe, M.D.)

Problems in Cerebellar Physiology. By GIUSEPPE MORUZZI. $3.25. Pp. 116. Springfield, Ill., Charles C. Thomas, 1950.

This monograph summarizes the results of recent neurophysiological studies on the anterior lobe of the cerebellum. Originally presented as four lectures at Northwestern University in 1948, the material has been edited and brought up to date with an excellent bibliography. The current phase of neurophysiological enthusiasm in the cerebellar influence on postural tone, the interrelations of cerebellar and cerebral motor cortex and cerebellar controls in the autonomic sphere are discussed. These topics are continuing subjects of investigation and controversy, and the use of the word "Problems" in the title justifies the lack of clarity or completeness sensed in the text. (Robert P. Woods, M.D.)

The Psychoanalytic Study of the Child, Vol. V. RUTH S. EISSLER, ANNA FREUD, and others, eds. $7.50. Pp. 410. New York, International Universities Press, 1950.

The range of this volume is considerable, covering original papers on the development and interpretation of analytic theory (Hartmann, Hoffer, Kris, Loewenstein, Rank, MacNaughton), observations on infant development (Spitz,), clinical and therapeutic problems (Greenacre, Jacobson, Lampl-De Groot, Fraiberg, and others), work with delinquents (Eissler, Bettelheim, Sylvester), work with parents (Schwarz, Rangell, Bonnard). This annual contribution to psychoanalytic literature is taking up and continuing successfully the function of the *Zeitschrift fur psychoanalytische Paedogogik* but is larger in scope. (Rudolf Ekstein, Ph.D.)

Society and Its Criminals. By PAUL REIWALD. $4.50. Pp. 315. New York, International Universities Press, 1950.

The author, a Swiss lawyer, toward the end of a long career made a study of psychoanalytic and psychiatric theory *in extenso*. He became greatly impressed with the contribution which the study of the unconscious could make to the control of crime. His book is annotated by many references to psychoanalytic sources, which he adapts and applies to his thesis.

This thesis can be impressionistically grasped from the following fragmentary quotations. "The history of criminal law (if an almost unbroken sequence of violent outbursts of emotion may be regarded as history) . . . compels us at every turn to face circumstances which do not admit of rational explanation, and to assume unconscious emotions in those inflicting the punishment" (p. 6). ". . . moral indignation and moral courage seem to be very different matters. If only a single judge had given such a declaration [a simple statement that neither conviction nor acquittal were possible unless the state of mind of the criminal was better understood] instead of a judgment, he might have directed our criminal justice into another channel" (p. 32). ". . . (anyone who visits prisons perceives quickly that) it is the rich who punish the poor" (p. 165). ". . . the criminal is necessary to man . . . for emotional reasons. Consequently, he organizes the fight against him so that at the same time it serves the purpose of maintaining crime" (p. 236). "What should replace aggression in criminal law? The Aichhorn experiment . . ." (p. 291). (K. A. M.)

Case Studies in the Psychopathology of Crime. Vols. III & IV. By BEN KARPMAN, M.D. $17.50 per vol., $28 per set. Pp. 2009. Washington, D. C., The Medical Science Press, 1948.

Five years ago Doctor Karpman brought out the first two volumes of a projected series in the studies on criminals made from his own point of view and by his own methods, both of which are somewhat unique.

Volumes III and IV contain the case records, the free associations, the treatments, and some of the correspondence of eight patients, all of whom had committed murder. The author has been very conscientious in recording details of the patients' productions. The result is a mass of material somewhat difficult to digest but which shows plainly that the deeds of some men are more terrible than the worst fantasies of others and that the treatment of these wrong-doers by our representatives in the penal system is the worst of all. (K. A. M.)

Giant Brains or Machines That Think. By EDMUND CALLIS BERKELEY. $4. Pp. 270. New York, Wiley, 1949.

Machines that compute, remember, learn and make their own decisions in doing the complex operations necessary to solve involved problems are among the latest and most important technological advances of our time. *Giant Brains* offers descriptions of the most important of these new machines and explains their principles of operation and application in a simple, understandable and entertaining way. Supplementary chapters take brief excursions into logic and language, as well as into the problem of the social control of such machines. The book is not only vastly interesting and stimulating in its own right but provides an object lesson in popular writing on difficult and technical subjects which should be a "must" for all who would make the understanding of specialized fields more widespread. (Herbert J. Schlesinger)

More About Psychiatry. By CARL BINGER, M.D. $4. Pp. 201. Chicago, University of Chicago Press, 1949.

Writing with simplicity, but not without that clinical keeness displayed in his past literary achievements, Dr. Binger has described psy-

chiatry in a manner that can easily be "digested" by both layman and physician. He takes up many problems that are now facing the enlightened practitioner in the realm of psychosomatic medicine and mental hygiene. Although he has hastily covered many serious and urgent needs of the individual, the community, and the world, Dr. Binger conveys his message in a most acceptable manner. This is due, in part, to his ability to use his past clinical experience in the best manner to illustrate his point. The medical student, practitioner, and layman will find this book stimulating, enlightening, provocative, and a stimulus for further reading in psychiatry. (Edward E. Baumhardt, M.D.)

Physiological Hygiene, ed. 3. By CLEVELAND PENDLETON HICKMAN. $5.15. Pp. 557. New York, Prentice-Hall, 1950.

This is a textbook for a college hygiene course. As such it attempts the difficult task of selecting what the layman should know about all the disciplines connected with health. It does this quite well. Its aim of keeping the layman abreast of the times in hygiene is too ambitious. There is a slight flavor of "how to be healthy in six easy principles." (James Behrman, M.D.)

Values and Personality: An Existential Psychology of Crisis. By WERNER WOLFF. $4.75. Pp. 239. New York, Grune & Stratton, 1950.

This author recently has been sending book after book through the presses. This book again bears witness of his high intelligence, his enormous reading, and his still more enormous ambition. Neither poorly defined concepts nor the intricacies of philosophical problems, likely to baffle slower thinkers for centuries to come, hamper him in his drive. In the present book he attempts to introduce into American psychology a "streamlined" version of the thinking done by European Existential Philosophy and philosophic psychology. He wishes that the reader may regard his Existential Psychology on a par with Freudian Psychoanalysis, Adlerian Individual Psychology, and Jungian Analytic Psychology. In contrast, however, to these systems, Wolff's work gives the impression of a synthetic product, not one grown out of an "existential" basis. (Paul Bergman, Ph.D.)

Mental Abnormality: Facts and Theories. By MILLAIS CULPIN. $1.60. Pp. 196. London, Hutchinson's University Library, 1950.

His ambitious aim to inform laymen of current views and advances in psychological medicine leads the author at times to omit or over-simplify, at times to elaborate unnecessarily. A lucid account is given of mental defectives and of certain legal or industrial psychiatric problems, but there is little information about recent advances in electroshock, subcoma insulin, antibiotics, anticonvulsants, or about modified psychoanalytic therapy as applied to groups and to selected psychotics, or about so-called brief psychotherapy. (L. Harold Caviness, M.D.)

Occupational Therapy: Principles and Practice. WILLIAM RUSH DUNTON, JR., M.D. and SIDNEY LICHT, M.D., eds. $6. Pp. 321. Springfield, Ill., Charles C. Thomas, 1950.

This is a collection of essays by several authors on different aspects

of what we here call the adjunctive therapies. The chapters on occupational therapy for psychiatric disorders, and the chapter which deals with recreational and other types of therapy are particularly good.

The reasons that some of us feel that the word "occupational therapy" ought to be replaced with a better one is illustrated by the fact that in the chapter of this book dealing with the principles of occupational therapy, recreation is dusted off with one and one-half lines, education with four, industries with three, and gardening with five. The excellent chapters by Davis on recreational therapy, and by Solomon on drama therapy have no clear relationship to occupation and these fields are not included in the topics dealt with in the chapter on prescription. (K. A. M.)

Journey into the Self. EDMUND FULLER, ed. $4. Pp. 331. New York, Crown Publishers, 1950.

This is a most revealing collection of letters and papers of Leo Stein, gifted esthete, and brother of the more celebrated Gertrude Stein. Included are some of Stein's brilliantly sensitive criticisms of twentieth century French painting. The book, tedious though it is at times, is also of interest because of the many references to Stein's own analysis as well as to his subsequent enthusiasm for group and self analysis. (Carl Epstein, M.D.)

Love Is Not Enough. By BRUNO BETTELHEIM. $4.50. Pp. 386. Glencoe, Ill. The Free Press, 1950.

From having attempted at various times to assist in preparing material describing our Southard School, the reviewer knows how difficult it is to convey the need and techniques, the philosophy and the results of the institutional treatment of children with emotional and behavior disturbances. Dr. Bettelheim tries various devices—photographs and drawings, dramatic case histories, prosaic case histories, running descriptions, and philosophical reflections. The material is good; its organization is only fair. The total effect is somewhat impaired by the difficulty of reading nearly 400 pages of such detailed data. But it is an important contribution to child psychiatry. (K. A. M.)

The Individual's Relation to Reality in Our Culture. By ELISABETH F. HELLERSBERG. MOLLY HARROWER, ed. $3.25. Pp. 128. Springfield, Ill., Charles C. Thomas, 1950.

The title of this monograph could more accurately be: An Introduction to the Horn-Hellersberg Test. This test is a semi-structured projective drawing completion technique in which various given lines within a series of squares are the basis of drawings freely made by the subject. After an interview with the subject about the meaning of the title and content of each drawing, personality analysis and diagnosis of psychopathology is made from the individual ways of dealing with reality revealed in the drawings. It is regrettable that Dr. Hellersberg did not have space to develop her culture-reality, acculturation concepts, and document them more liberally from the ample source materials she has. This test has rich psychodiagnostic possibilities. It is recommended as a diagnostic tool for clinical psychologists, a research tool for anthropologists, sociologists and other investigators of personality expression. (Walter Kass)

The Mask of Sanity, ed. 2. By HERVEY CLECKLEY. $6.50. Pp. 569. St. Louis, C. V. Mosby, 1950.

This is a complete revision with the addition of some new material. The author considers the psychopathic personality to be due to an inability to integrate important emotional experiences into the personality. This results in an inability to grasp or utilize experience in its real significance or meaning, to which the author applies the term "semantic disorder." A dynamic formulation for the development of the disorder is not presented. Some cases, he says, may be explainable in terms of Alexander's concept of the neurotic character. He does not consider carefully the possibility that psychopathy may be due to a disturbance of superego development. (E. G. Feldman, M.D.)

Textbook of Abnormal Psychology, ed. 4. By ROY M. DORCUS and G. WILSON SHAFFER. $5. Pp. 717. Baltimore, Williams & Wilkins, 1950.

Three new chapters appear in this edition: Brain Damage Disorders, Psychosomatic Disorders, and The History of Mental Illness. A glossary has also been added. Like the previous editions, it is characterized by an eclectic point of view and a comprehensive review of the literature (1200 references are cited). "Psychoanalytic and Instinctive Theories" are dealt with in one short section, and the authors are probably correct when they predict for this material "the likelihood of protestations from various sources." Although the style is pedestrian and the chapters on sensory and motor disorders are unnecessarily detailed, as a reference book it will no doubt serve a useful purpose. (Robert C. Challman, Ph.D.)

Schizophrenic Art: Its Meaning in Psychotherapy. By MARGARET NAUMBURG. $10. Pp. 247. New York, Grune & Stratton, 1950.

"Process" reports of what goes on in a long-term relationship between a patient and an art or crafts therapist are rare, so Miss Naumburg's handsomely illustrated account of two cases is an especially valuable contribution. A scholarly discussion of artistic creations of the mentally ill and an appendix of poetry by the same two patients enrich the book. The author's therapy stresses rather insistent questioning and prodding, analysis, insight, and "release" of old memories. She gives perhaps too little credit to her own sustained warmth and interest. (Aaron Paley, M.D.)

Humanity and Happiness. By GEORG BROCHMANN. $3. Pp. 244. New York, The Viking Press, 1950.

A philosophy of human experience written by a layman who somehow knows the truths of the ages—the truths of religion, philosophy, and psychoanalysis—and who can express them with depth and breadth of understanding. He wrote this during the Nazi occupation of his native Norway. Successive sections cover man's ages from childhood through old age and death with sections on daydreams, play, and heroism. (Murray Bowen, M.D.)